### Health Information and Quality Authority

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name</th>
<th>St Colmcille's Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005531</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Oldcastle Road, Kells, Meath.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>046 924 9733</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:stcolmcillesnh@eircom.net">stcolmcillesnh@eircom.net</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Fáinleog Teoranta</td>
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<tr>
<td>Provider Nominee:</td>
<td></td>
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<tr>
<td>Lead inspector:</td>
<td>Vincent Kearns</td>
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<td>Support inspector(s):</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>35</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>7</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 05 December 2017 07:30
To: 05 December 2017 18:00
From: 06 December 2017 07:30
To: 06 December 2017 15:30

The table below sets out the outcomes that were inspected against on this inspection.

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<tr>
<th>Outcome Description</th>
<th>Our Judgment</th>
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<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
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<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Major</td>
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Summary of findings from this inspection
This report sets out the findings of a two day unannounced triggered inspection following receipt prior to this inspection of unsolicited information of concern received by the Health Information and Quality Authority (HIQA). These concerns alleged issues including inadequate staffing and a poor quality of care provided to residents. The inspector found evidence during this inspection to partially substantiate these concerns, particularly in relation to the inadequate suitable staffing. This was the centers second triggered inspection this year following receipt of unsolicited information of concern received by HIQA.

The inspector focused on the issues identified in unsolicited information of concern and also monitored progress on the actions required arising from the last inspection carried out on 23 June 2017. The inspector met with residents, relatives, the provider representative, the person in charge, the healthcare manager, the Mowlam group director of care services and staff members during the inspection. He also observed practices and reviewed documentation such as policies and procedures, care plans,
medication management, staff records and accident/incident logs.

Overall, the atmosphere within the center was homely, comfortable, in keeping with the statement of purpose and assessed needs of the residents who lived there. The inspector saw that residents’ healthcare needs were generally met and they had access to appropriate medical and allied healthcare services. There was a homely ethos and respect and dignity for residents was evident. In this relatively small center, the inspector observed that staff connected with residents as individuals and staff were observed interacting with residents in a respectful, positive and warm manner. Overall residents appeared to be well cared for and residents and relatives spoken to gave positive feedback regarding many aspects of life in the center. The inspector found that staff were knowledgeable about residents’ likes, dislikes and personal preferences. The inspector spoke with a number of residents and visitors who confirmed that residents were well cared for, felt safe and were happy living in the center.

From the 11 outcomes reviewed during this inspection, three outcomes were compliant and three outcomes were deemed to be substantially compliant: statement of purpose, safeguarding and safety and residents rights, dignity and consultation. In addition, four outcomes was found to be moderately non-compliant: governance and management, health and safety and risk management, and health and social care needs. A major non-compliance was found in relation to the provision of suitable staffing. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centers for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The statement of purpose and function was viewed by the inspector and this document was recorded as having been most recently reviewed in July 2017. It described the service and facilities provided in the center. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated center's registration under Section 50 of the Health Act 2007. There was evidence that the statement of purpose was kept under review and readily available for residents and staff to read with copies available in the sitting room and near the main entrance.

On the previous inspection improvements were required in the statement of purpose in relation to accurately recording the deputizing arrangements for the absence of the person in charge as the person recorded as being responsible for in the person in charge's absence was no longer working in the center. On this inspection, the statement of purpose stated that "when the Person in Charge was absent, in their place, the Clinical Nurse Manager (CNM) was in charge. However, the inspector noted that the CNM had recently resigned and while a replacement CNM was due to commence working in the centre the following week, the statement of purpose had not been amended to reflect this new deputizing arrangement.

**Judgment:**
Substantially Compliant

**Outcome 02: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient
resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Since the previous inspection there had been some improvements noted for example, a new computerized care planning system had been established, the upgrade program for the premises had commenced with some new furniture in place and new cleaning equipment was due to be delivered. There were painters working in the main entrance and corridors on the days of this inspection. The inspector noted that seven of the 11 actions required from the previous inspection had been adequately progressed. There was evidence of good consultation with residents and their relatives. All residents and visitors to whom the inspector spoke stated that they were happy with the service provided and they were kept well informed. Residents appeared well cared for and were complementary of the care and support they received from staff. The overall atmosphere in the centre was homely, welcoming and it was warm, bright, clean and well ventilated on both days of inspection.

One of the two actions under this outcome from the previous inspection had not been adequately progressed and remained open and was restated in this report. This action was in relation to ensuring that the management systems were in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This finding was evidenced by the culmination of the following:

- the centre has been moving away from compliance as evidenced by non-compliances identified on this and the previous inspection, both of which were triggered inspections following receipt of unsolicited information of concern
- the continued failure to provide adequate staffing, this non-compliance was also identified on the previous inspection and was of significant concern due to the recent changes in the center including recent change of provider, recently appointed person in charge, new healthcare manager and a number of recent staff changes in the center
- the significant failings identified on this inspection across a number of outcomes
- the rostering on night duty and evening shifts of recently recruited nurses from a different jurisdiction, with limited experience in older person care and no training in dementia care or challenging behaviors. These nurses operated with less supervision/support than staff on day duty.
- the absence of staff appraisals particularly in the context of the aforementioned recently recruited staff and on-going changes in the center.

Throughout the two days, the inspector spoke to both the person in charge and the recently appointed healthcare manager. The healthcare manager outlined her role in supporting the person in charge in the management of the center. The inspector noted
that the healthcare manager had significant clinical and management experience in the care of older persons. She met the person in charge regularly and at a minimum each week and was also in regular phone contact. The person in charge outlined the significant governance, processes and systems changes that had occurred in the center over the past year. Both the person in charge and the healthcare manager explained their areas of responsibility and were found to be suitably knowledgeable and resident oriented, in their approach. They were aware of the regulations governing the sector and the national standards. There was evidence of good consultation with residents and relatives from speaking to residents and visitors, from a review of care plans and minutes of residents’ committee meetings. The provider representative confirmed that resources were available to ensure the premises refurbishment and on-going premises upkeep as well as the continuous professional development of staff. There were some management systems in place in relation to ensure that the service provided was monitored and safe. Clear lines of accountability and authority were evident in the center. The inspector found that key aspects of the service and key clinical parameters were audited including resident falls, complaints and care standards. With the establishment of the computerized care planning, incident and complaints reporting system; accountability within the center had been streamlined. This system was supported by an electronic data management reporting system which facilitated transparency regarding care provision and risk management. In addition, this data was readily accessible to the provider representative and all members of the management team. Data collated was analyzed and action plans were developed to inform areas requiring improvement. The healthcare manager informed the inspector that the annual review into the quality and safety of the center would be completed in December 2017 and would be based on the quality and safety meetings and customer satisfaction and feedback surveys.

Nursing staff to whom the inspector spoke confirmed that there was always a manager on call in the center and they knew who was available each day and night. There was a escalating process to contacting management. Staff would contact the person in charge in the first instance and if she was not available staff would then contact the healthcare manager and again if she was not available, they could contact the group director of care services in this order. However, the inspector requested a review of this system to ensure that the on call arrangement was clear to all staff and that this process and its operation was clearly recorded throughout each week.

**Judgment:**
Non Compliant - Moderate

**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
An action from the previous inspection was in relation to the person in charge not having sufficient time to be fully engaged in the effective governance, operational management and administration of this center due to the demand of her involvement and responsibilities across two centers. However, on this inspection the inspector noted that the person in charge was now responsible for this one center and she was fully engaged in the governance and administration of this center on a consistent basis.

The person in charge had been appointed to this post in March 2017 and worked full time in the center and was a registered nurse with experience in the area of nursing the older person. The person in charge was also an experienced nurse manager and had previously worked in the role of an Assistant Director of Nursing and an Acting Director of Nursing in another center. During the two days of the inspection, the person in charge demonstrated adequate knowledge of the legislation and of her statutory responsibilities. She was clear in her role and responsibilities as person in charge. She met regularly with residents and their representatives, the members of the management team, most of the care and nursing staff. Minutes were maintained of these meetings.

The person in charge had completed a postgraduate management qualification in 2016 and she was supported by a healthcare manager, the director of care services and the provider representative. In addition, there had been a CNM who had deputised in the absence of the person in charge. The inspector was informed by the provider representative that this person had recently resigned however, an experienced CNM was shortly due to commence working in the center to cover the person in charge in her absence.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated an adequate understanding of safeguarding and prevention of elder abuse. The inspector spoke to the majority of the
available staff working in the center on both day and night duty. All staff spoken to were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. There were suitable policies and procedures in place to guide staff in the care and protection of residents. For example there was a policy on safeguarding and elder abuse and a policy on the use of restraint. Each of these policies were recorded as being reviewed in August 2017. Safeguarding training was provided to all staff and refresher training was provided on an on-going basis in-house. Staff training records and staff spoken to provided evidence that all staff had received up-to-date training in a programme specific to protection of older persons.

The person in charge confirmed that the center did not manage any pensions for any residents living in the center. The center maintained day to day expenses for a small number of residents and the inspector saw evidence that adequate financial records were maintained. All lodgments and withdrawals were documented and were signed for by staff members and the inspector was informed that the person in charge monitored these records in conjunction with administration staff.

The inspector noted that there were 10 residents with a diagnosis of dementia and a number of other residents with varying levels of cognitive impairment living in the center. There was a policy on the management of behavior's that challenge that was most recently reviewed in August 2017. The inspector observed staff were kind and respectful towards residents in all of their interactions during this inspection. Residents with symptoms involving behavior's that challenge appeared well cared for and had behavioural support care plans in place. Staff spoken to were aware of the triggers and the most effective person-centred interventions to de-escalate any incidents of behavior's that challenge. However, most but not all staff had been provided with training in the management of behaviors that challenge or with training in a dementia care. In addition, some of these staff were recently recruited from a different jurisdiction, working with reduced support (on night duty) and had limited experience of care of older persons. The absence of this mandatory training combined with a lack of suitable clinical experience of some staff was of concern to the inspector and was therefore also referenced under outcome 2 of this report.

There was evidence that for the few residents who presented with behaviors that challenge were reviewed by their General Practitioner (GP) or referred to other professionals for full review and follow up as required. Since the last inspection a number of rummage boxes have been made available and the inspector was informed that residents were availing of same. Care plans reviewed by the inspector for residents exhibiting behaviors that challenge were seen to include positive preventative and management strategies. These were clearly outlined in residents' care plans and therefore ensured continuity of approach by all staff using person-centred de-escalation methods.

There was a policy on restraint which was updated in August 2017. There was evidence that the use of restraint was generally in line with national policy. The restraint register recorded three residents using bedrails on the days of the inspection. On the previous inspection there had been improvement required in records of safety checks undertaken when bed rails were in use. On this inspection the inspector noted that safety checks were comprehensively completed. For all residents with any form of restraint; there was
evidence that there was regular checking/monitoring of residents, discussion with the resident's family and the GP. The inspector saw that there was an assessment in place for the use of restraint, which identified what alternatives had been tried to ensure that the particular form of restraint was the least restrictive method to use. Overall, the inspector was assured by the practices in place and saw that whenever possible alternative measures were used. For example there were low-low beds and alarm mats used for a number of residents to reduce the use of bed rails in the center. However, the risk assessment for the use of bed rails required review as it did not quantify the actual level of individual risk associated with the use of the bed rails. This issue was actioned under outcome eight of this report. The inspector also noted there had been a continued reduction in bed rail usage since the last inspection. The center was located adjacent to a busy road and the inspector observed that aside from two fire exit doors, all exit doors in the center were accessible via the use of digital coded locks. Residents and visitors could press a door bell/call bells or ask staff if they wished to use these doors. However, this environmental restraint had not been managed or recorded line with national restraint policy.

Judgment:
Substantially Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was a risk management policy as set out in schedule 5 of the regulations and included all of the requirements of regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the center which covered for example, risks such as residents' falls, fire safety risks and manual handing risks. There was a center specific safety statement dated as being most recently reviewed in September 2017. The inspector was informed that the healthcare manager and/or the provider representative and the person in charge met each month to review health and safety issues including any incidents, accidents or near misses in the center. This meeting also reviewed procedures and practices including risk management and fire safety in the center. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency and assessments for pressure ulcer formation. There center had recently moved from a paper base to a computerized care planning and recording system. All accidents and incidents were recorded via this system on incident forms. All were reviewed by the person in charge, healthcare manager and provider representative and there was evidence of action in response to individual incidents. There was recorded
information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. The inspector noted that a significant number of risk assessments were still recorded in a paper format and had not yet being transferred onto the new computer system. However, many of these paper based risk assessments required review as they had not been reviewed since 2013/2014 and therefore they may for example not have had suitable current controls in place to mitigate identified hazards. The inspector reviewed all notifications made to HIQA and crossed referenced them against the recorded accidents in the center. The inspector noted that suitable notifications had been made in relation to all accidents in the center. However, the hazard identification process required improvement as a number of potential hazards were identified by the inspector that required action including:

- the unrestricted access to the staff changing room required risk assessing
- the lack of storage racks in one sluice room potentially compromised the prevention of cross contamination practices
- the unrestricted access to the kitchen staff changing room required risk assessing
- the two unrestricted fire exit doors required risk assessing
- there were no call bells available in the oratory room or the visitors toilet and required review to ensure compliance with regulations
- the risk assessments for the use of bed rails required review as they did not quantify the actual level of individual risk associated with the use of the bed rails.

Overall there were systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. The communal areas and bedrooms were found to be clean and there was good standard of general hygiene in the centre. The inspector was informed that the center had a new supplier of cleaning and laundry products and new cleaning trolleys were due to be delivered. Staff that were interviewed demonstrated knowledge of the infection prevention and control procedures to be followed or demonstrated suitable hand hygiene practices. All hand-washing facilities had liquid soap and paper towels available. There were center specific policies and procedures in place on infection prevention and control. However, there were a number of infection control issues including:

- the material of the back support in two shower chairs was discoloured and appeared unclean
- the water taps of the wash hand sinks in the center's sluice facilities were not adequate as they were domestic in design and did not promote good hygiene and infection control practices
- the cleaning practices as described to the inspector did not promote effective cross contamination prevention practices.

There was fire safety training provided by an outside fire safety instructor, with the most recent training recorded as provided in September 2017. All staff spoken to demonstrated an appropriate knowledge and understanding of what to do in the event of fire. There were fire policies and procedures that were center-specific. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Fire fighting and safety equipment had been regularly tested, the fire alarm and the emergency lighting was last tested in November 2017. All staff spoken to stated
that they had participated in a fire evacuation drill in the center. The person in charge outlined how fire evacuation drills were practiced regularly in the center with the most recent completed in November 2017. Some residents to whom the inspector spoke to were knowledgeable about the fire safety arrangements in the center including the fire evacuation drills and stated that they would recognize the sound of the fire alarm. Staff spoken to knew the evacuation requirements for each resident. The inspector was informed that residents' personal emergency evacuation plans (PEEP's) were being completed for each resident living in the center. However, the inspector noted that many residents had not yet had their PEEP’s completed. In addition, the following fire safety issues required review:

- there was no consistent call bell facility available for residents to call for assistance while using the smoking area
- the smoking risk assessment record required review to include the management and storage of residents' cigarette lighters and matches
- the absence of a fire safety blanket from the smoking area required to be risk assessed
- the current location of the fire extinguishers to the smoking area in the center required to be risk assessed.

Judgment:
Non Compliant - Moderate

**Outcome 09: Medication Management**
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The centre-specific policies on medication management were made available to the inspector and were recorded as been most recently reviewed in April 2017. These policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were made available to nursing staff who demonstrated adequate knowledge of this document. Nursing staff with whom the inspector met outlined a robust procedure for the ordering and receipt of medicines in a timely fashion. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines for residents were supplied by a community pharmacy. The inspector was informed that the pharmacy provided regular medication audits and that the center conducted a weekly medication audit. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range and the temperature was monitored and recorded daily.
Medication administration was observed and the inspector found that the nursing staff adopted a person-centred approach and a sample of medication prescription records was reviewed. Medicines were generally recorded and administered in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais (Irish Nursing and Midwifery Board of Ireland). Compliance aids were used by nursing staff to administer medicines. A sample of medication prescription records was reviewed and each medication prescription was reviewed by the residents' GP every four months or more often, if required. The inspector noted that one resident who had been admitted to the center two days previously did not have any medication kardex available. The inspector was informed that the resident had been transferred from hospital without any medication kardex. Just prior to admission to the center, this resident had suffered two fractures. While this resident did not report any pain at the time of this inspection however, the inspector noted that there was no baseline record of this resident's pain level and this resident had not been reviewed by a GP in relation to their potential requirement for pain relief medication. This issue was discussed and action under outcome 11 of this report.

Medications requiring additional controls under the Misuse of Drugs Regulations (MDR) were seen to be suitably stored and there were measures in place for the handling and storage of controlled drugs in accordance with current guidelines and legislation. These measures included the stock checking of all medications by two nurses at the end of both the day and night duty shifts. There was a MDR stock balance record kept that required the signatures of both nurses who had checked the stock and confirmed that the stock balance was correct. However, the inspector noted that the MDR stock balance record was not in compliance with regulations as there was only one and not two nurses' signatures recorded in the stock balance record on a number of entry dates in October and November 2017.

Judgment:
Non Compliant - Moderate

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Unsolicited information of concern had been received by the Health Information and
Quality Authority (HIQA) prior to this inspection. Part of this concern alleged issues in relation to poor quality of care provided to residents. However, during this inspection the inspector found little evidence to substantiate these particular concerns.

The action from the previous inspection in relation to reporting of clinical observations and the monitoring of relevant information known following a significant change in a resident's condition had been. The inspector attended the morning staff handover meetings on both days of this inspection. The inspector noted that the staff nurse on night duty gave updates on all residents care and support needs from the previous night to incoming day duty staff nurses and healthcare staff. There was a prepopulated handover record used by staff to ensure an accurate handover meeting occurred. This record promoted residents' safety by reducing the potential for errors in communication and provided incoming care staff with pertinent resident information. The person in charge outlined how the center had recently moved from a paper based care recording system to an electronic based care recording system. The inspector observed staff inputting records of on-going care provision using touch screens that were located in a number of areas in the center.

The person in charge outlined how all prospective residents were assessed by a member of the nursing management team. This pre-admission assessment was carried out to ensure that each resident met the admission criteria as stated in the centers' statement of purpose. The inspector noted that the center catered for low to maximum dependency residents including residents with dementia, disabilities and provided respite, long term care, convalescent and palliative care. Following the assessment the planned admission was communicated in detail to the nursing staff to arrange transfer/admission. The inspector noted that on the days of inspection there were 18 residents assessed as having maximum dependency, nine residents assessed as having high dependency needs, six residents as having medium care needs and two residents as having low dependency care needs.

The inspector saw that most residents had a comprehensive nursing assessment completed following admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. There was evidence of access to specialist and allied healthcare services to meet the care needs of residents. For example, speech and language therapist (SALT), psychiatry, opticians, dentists and chiropody services. Access to palliative care specialists, dietician and onsite physiotherapy were also available. On the first day of the inspection the inspector met a palliative care nurse specialist who was visiting the center to provide staff training. There was a keyworker nurse allocation system in place which ensured that each resident was allocated to an individual nurse that monitored the assessment, planning, implementation and review of healthcare needs for individual residents. Each keyworker was also responsible for the nursing assessments, care plans and clinical risk assessments. The person in charge stated that she monitored the care planning system to ensure that residents support and care needs were met. Overall, the inspector found that most care plans were person centered and individualized. Most nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs.
Residents appeared well cared for and residents to whom the inspector spoke were complementary about the care they received from staff. Assessments and care plans were reviewed four-monthly or more frequently as required. A daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. This computerized care planning system facilitated high visibility in relation to the monitoring of care plans regarding residents' assessments, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments such as smoking risk assessment for residents who smoked cigarettes. However, the inspector noted that the smoking risk assessment required review to include the storage and management of cigarette lighters and matches. This issue was actioned under outcome eight of this report.

Residents had access to General Practitioner (GP) services. For most residents there was evidence of regular reviews of residents overall health on admission and on readmission following return from acute hospital care, and as required when clinical deterioration was noted. As stated under outcome nine of this report, one resident who had recently suffered two fractures had been admitted to the center two days previously. The inspector was informed that the resident had been transferred from hospital without any medication kardex and the inspector noted that this resident still did not have any medication kardex available. While this resident did not report any pain at the time of this inspection however, the inspector noted that this residents level of pain had not been recorded as assessed therefore there was no baseline record of this residents' pain level. In addition, this resident had not been reviewed by a GP, particularly in relation their potential requirement for pain relief medication. The person in charge informed the inspector that the residents' would be seen by the GP that afternoon.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Only the actions from the previous inspection were reviewed in this outcome as part of
this inspection and the inspector noted that all identified issues from the previous inspection were either in progress or had been satisfactorily completed.

On this inspection the inspector noted that the upgrade program for the premises had commenced for example, there were five outside contracted painters observed working in the center on the days of the inspection. The person in charge outlined how there had been some new furniture sourced with more due to be delivered. The communal areas and bedrooms were found to be clean and overall there was good standard of general hygiene evident in the center. The inspector was informed that the center had a new supplier of cleaning and laundry products and new cleaning trolleys were due to be delivered. However, as discussed and actioned under outcome 8 of this report
● the material of the back support in two shower chairs was discoloured and appeared unclean
● the water taps of the wash hand sinks in the center's sluice facilities were not adequate as they were domestic in design and did not promote good hygiene and infection control practices
● the cleaning practices as described to the inspector did not promote effective cross contamination prevention practices.

The healthcare manager informed the inspector that new mattresses / cushions had also been acquired. Some of the television wall brackets and stands had been adjusted to ensure that they were suitably positioned. Equipment such as lifting hoists and laundry trolleys were suitably stored. The room temperatures were maintained at the appropriate levels and monitored on a weekly basis by the maintenance personnel. Residents and staff to whom the inspector spoke confirmed that there was sufficient water available and the inspector noted that the water was at the appropriate temperature. There was a maintenance log available in the center which staff used to report issues to maintenance staff such as broken equipment. This record was also used by maintenance staff to record what issues had been remedied.

Judgment:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/ her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The action from the previous inspection had been completed. There was a person nominated to oversee that all complaints were appropriately responded to and adequate
records were in place. On review of the complaints log there was evidence that complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcome of their complaint and records evidenced whether or not they were satisfied. Overall policies and procedures which complied with legislative requirements were in place for the management of complaints with the center specific complaints policy reviewed in July 2017. There was an independent appeals process and complaints could be made to any member of staff. The person in charge was the designated complaints officer. Residents and their representatives were aware of the complaints' process which was on public display near the entrance to the center. However, the provider representative agreed to this notice to ensure that it was easily readable as the inspector noted that the size of the text was small and may have been difficult for some residents or/and visitors to read.

**Judgment:**
Compliant

**Outcome 16: Residents' Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Since the last inspection there had been some improvements in the activity programme and residents stated that they enjoyed the available activities. On the afternoon of the first day of the inspection a mini bus had been organized to transport six residents on a shopping trip to Navan town for the evening. The inspector spoke to two of the activities coordinators and noted that a programme of varied internal activities was in place for residents. Information on the day's events and activities was prominently displayed in the center. Residents described crosswords, bingo and various games were the most popular. One resident described how as a previous darts player he always won any of the throwing games. The inspector was informed that activities provided also included the use of music, movement and the use of props. The inspector noted that the large ball game, loops or rings seemed to be particularly popular with residents. However, an action from the previous inspection in relation to the role of the activity coordinator to be reviewed to ensure that they could dedicate their time to providing activities for residents had not been progressed satisfactorily and was therefore restated in this report. The inspector noted that the activities coordinators were required to stay in the
vicinity of the main sitting room to ensure monitoring of residents and to assist in the provision of residents’ drinks in the morning and afternoon. The inspector observed that a number of residents choose not to spend time in the sitting room while others were unable to attend the main sitting room. Therefore this arrangement for activities coordinators to stay in the main sitting room significantly reduced the opportunity for the provision of one to one activities in residents rooms or at other locations in the center.

There was evidence that residents were consulted with and participated in the organisation of the center. The inspector observed that overall, residents’ rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. Residents spoken with confirmed that they were afforded choice in relation their daily lives and for example receive visitors in private. The inspector spoke to a number of visitors and one visitor described how she regularly visited her mother and was feel welcome by staff. There were no restrictions to visiting in the centre and the inspector noted several visitors at different times throughout the two day inspection. There was a visitors record book available near the entrance to the center.

Residents were facilitated to exercise their civil, political and religious rights. A Eucharistic Minister visited frequently and there was an oratory available within the centre for prayer or quite reflection. Residents had access to a private telephone and local and national newspapers were available. Residents right to choice, and control over their daily life was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Evidence that residents and relatives were involved and included in decisions about the life in the centre was viewed. Monthly residents meetings were held where residents were consulted through the residents' committee meetings. The inspector noted a high number of residents attended these meetings. The activities coordinator chaired this meeting and she outlined that the role of this meeting was to ensure that residents’ actively participated in decision making and to provide and receive feedback in relation to life in the center. The person in charge and the activities coordinator met regularly to review any issues raised at the residents' committee meetings. There was evidence of changes having been made as a result of these meetings. For example, there had been an a concern raised about security and the activities coordinator and person in charge arranged fro a community Garda to come a speak to a group of residents in relation to maintaining personal safety. Some residents spoken to by the inspector stated that this meeting had been very informative and reassuring.

Judgment:
Substantially Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Prior to this inspection, unsolicited information of concern had been received by HIQA in relation to alleged inadequate staffing to meet the needs of residents. However, during this inspection the inspector found evidence to substantiate these concerns and formed the view that staffing arrangement was not appropriate to the needs of the residents and the size and layout of the center. This view was informed by the following:

On the previous triggered inspection of June 2017 similar issues had been identified including: this previous report stated “however, while there was a nurse on duty at all times, the nursing staff complement reduced from two nurses to one nurse from 6pm to 8pm every evening... this resulted in a change of practice relating to the reviewing of controlled drugs which required improvement”, this report also stated "a review of staffing levels was required".

On this inspection the inspector was informed that the nursing staff complement had again recently been reduced from two nurses to one nurse. This time from 4pm to 8am each day. The inspector was informed that this occurred when the number of residents living in the center had reduced to 30 residents. However, the inspector formed the view that this staffing arrangement was not appropriate to meet the needs of the residents and the size and layout of the center due to the following:

- on the first morning of this inspection the inspector noted that there were 35 residents living in the center; 27 of these residents had been assessed as having a high to maximum dependency needs. The inspector was informed by staff that residents with such dependency generally required the assistance of two staff working in pairs.
- the inspector noted that to help prevent residents from falling; one staff was required to stay in the vicinity of the sitting room at all times, when residents were in this room. Therefore resulting in only three staff being available to assist residents in the busy evening period and whenever the nurse was busy, this number was reduced to only one pair of staff available to provide direct support for the 27 residents with a high/maximum dependency care needs
- the inspector observed that in addition to providing direct nursing care; the one remaining nurse had many other duties each evening. For example, on the evening of the first day of inspection the inspector observed the nurse dealing with residents and visitors queries, answering phone queries form pharmacy/GP's and conducting the evening medication round
- the inspector noted that the most recent admission to the center had occurred the previous evening, when there was only one nurse available
- the vast majority of staff to whom the inspector met on both day and night duty over the course of the two days of inspection repeatedly highlighted this issue regarding inadequate staff to meet residents' needs. The overwhelming majority stated that the
recent reduction of staff nurse hours significantly impacted on staff ability to effectively meet residents' needs.

● the inspector noted from a review of the minutes of residents committee meetings; concerns in relation the amount of time staff had to provide residents with assistance had also been raised by some residents at these residents meetings.

This issue was also referenced under outcome 2 of this report and in response to the above, the provider representative informed the inspector that there would be an additional healthcare assistant on duty from 4pm until 10pm each day in the center commencing immediately.

The inspector observed warm interactions between staff and residents and observed staff chatting easily with residents. Residents spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to residents.

The center was divided into two sections with one staff nurse when available, allocated to each section. An actual and planned roster was maintained in the center. The inspector reviewed a sample of staff rosters which showed that the person in charge was now on duty Monday to Friday in the center and that she was supported in her role by the healthcare manager, staff nurses and up until recently the CNM. The inspector was informed that the CNM had recently resigned from her post. However, the provider representative stated that another experienced CNM was due to commence working in the center in the next number of days.

The inspector observed practices and spoke with a majority of the staff available over the two days of inspection. This staff included the person in charge, the activities coordinators, cleaning and household staff, healthcare assistants, the healthcare manager and the chef, the administrator, staff nurses on both day and night duty and the provider representative. The previous inspection report stated that “while they had not conducted appraisals of staff to date, a schedule of appraisals was planned from September of this year”. However, the inspector was informed that appraisals had not commenced in the center. This issue was also referenced under outcome 2 of this report.

Records viewed by the inspector confirmed that overall there was a good level of training provided with further training dates scheduled for 2017. The inspector was informed that mandatory training was on-going and staff had attended a number of trainings with most staff had completed mandatory training in areas such as fire training and safeguarding and safety. Mandatory training in manual handling was found to be up to date for most staff. Further manual handling training was scheduled in January 2018 however, one recently recruited staff had not been provided with manual handling training, this presented a potential risk for the safety of residents and staff.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. The provider representative confirmed that all staff and volunteers had suitable Garda vetting in place. Registration details with Bord Altranais agus Chnámhsheachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector.
Some improvements were noted since the last inspection for example, the person in charge who had divided her time between two centres, was now based full-time in this centre. While both the person in charge and the healthcare manager stated that they were available if required to be contacted out of hours however, the system for such arrangements required review to ensure that it was clearly indicated/recorded as to whom staff could contact for managerial support out of hours. This issue was actioned under outcome two of this report.

Judgment:
Non Compliant - Major

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Vincent Kearns
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name</th>
<th>St Colmcille’s Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005531</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>05/12/2017</td>
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<tr>
<td>Date of response:</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Statement of Purpose

**Theme:**
Governance, Leadership and Management

The **Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
To prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 including the deputizing arrangements for the absence of the person in charge.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The Statement of Purpose has been amended to include the deputising arrangements for the absence of the person in charge. The updated version will be submitted to the authority.

**Proposed Timescale:** 31/01/2018

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**Outcome 02: Governance and Management**

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
To put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**2. Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
- The Person in Charge (PIC) is supported by a newly appointed CNM who commenced in her role on 11/12/17. She will support the PIC with the quality and safety of clinical care in the centre.
- The PIC reports directly to a regional Healthcare Manager, who visits the centre regularly and provides advice and support regarding the overall management of the centre and monitors regulatory compliance.
- The PIC completes a weekly report, outlining all aspects of quality, safety, capacity and capability in the centre. Any anomalies are investigated and resolved.
- A monthly management team meeting is held in the centre, attended by the Healthcare Manager, chaired by the PIC and including a member of each department in the centre. The agenda of the meeting is to review the quality and safety of the centre; staff are informed about developments, their views and suggestions are welcomed and they have an opportunity to actively contribute to quality improvement initiatives in the centre. An Action Register is documented and updated at each meeting, including a progress review on identified actions.
- A detailed review of a specific aspect of quality and safety is undertaken each quarter at this meeting; for example, a strategy for prevention and management of falls; and improvement plans will be discussed.
- An annual review of Quality and Safety will be undertaken in January 2018; following this a broad strategy to improve quality and safety in the centre in the coming year will be determined.
Proposed Timescale: 28/02/2018

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that all staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

3. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
All staff in the centre will receive education and training in the care of a resident with a diagnosis of dementia and in managing responsive behaviours. All staff who have already received this training will receive refresher sessions to ensure that their skills and knowledge are up to date and consistent with the centre's policy on caring for people with dementia and responsive behaviours. Dementia care and Challenging Behaviour Training has been booked for delivery on 10/01/2018.

Proposed Timescale: 28/02/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To take all reasonable measures to protect residents from abuse including ensuring that any environmental restraint is managed or recorded line with national restraint policy.

4. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Bed rails have now been risk rated and this has been entered on the electronic Risk Register.
All staff in the centre will receive education and training in Safeguarding Vulnerable Persons at Risk of Abuse and they will be able to recognise and report any suspicions of abusive behaviour appropriately. Staff will also receive regular refresher training.
Proposed Timescale: 28/02/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including:
- the unrestricted access to the staff changing room required risk assessment
- the lack of storage racks in one sluice room potentially compromised the prevention of cross contamination practices
- the unrestricted access to the kitchen staff changing room required risk assessment
- the two unrestricted fire exit doors required risk assessment
- there were no call bells available in the oratory room or the visitors toilets required review to ensure compliance with regulations
- the risk assessments for the use of bed rails required review as they did not quantify the actual level of individual risk associated with the use of the bed rails.

5. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The following work will be completed:-
- An access lock will be fitted to the staff changing room
- Additional storage racks will be installed in the identified sluice room
- An access lock will be fitted to the kitchen staff changing room
- The two unrestricted fire exit doors will be reviewed and risk assessed
- Call bells will be fitted to the oratory and the visitors toilet
- Bed rails have now been risk rated and this has been entered on the electronic Risk Register.

Proposed Timescale: 31/03/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1) including reviewing all risk assessments at suitable intervals to ensure effective hazard identification to control identified risks in the center.

6. **Action Required:**
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

**Please state the actions you have taken or are planning to take:**
A complete review of all risk assessments and ratings is taking place and all risk assessments will be added to the electronic risk register.

**Proposed Timescale:** 31/03/2018

**Theme:**
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To make adequate arrangements for reviewing fire precautions including the provision of suitable personal emergency evacuation plans for all residents.

7. **Action Required:**
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

**Please state the actions you have taken or are planning to take:**
The Personal Emergency Evacuation Plans have been reviewed and include the information required for all residents.

**Proposed Timescale:** 31/01/2018

**Theme:**
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To make adequate arrangements for detecting, containing and extinguishing fires including reviewing the following fire safety issues:
- there was no consistent call bell facility available for residents to call for assistance while using the smoking area
- the smoking risk assessment record required review to include the management and storage of residents cigarette' lighters and matches
- the absence of a fire safety blanket from the smoking area required to be risk assessed
- the current location of the fire extinguishers to the smoking area in the center required to be risk assessed.
8. **Action Required:**
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
A full risk assessment of the smoking arrangements and facilities for residents will be conducted and recommendations implemented, including the provision of a call bell facility to enable residents to summon assistance as required.

The Fire Safety Training Officer will conduct a survey of the area, including the appropriate location for fire extinguishers or other required fire safety equipment in the smoking area.

Individual risk assessments have been completed on each resident who smokes to determine the level of supervision required and this includes individual arrangements for the management and storage of cigarette lighters and matches.

**Proposed Timescale:** 31/03/2018

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**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
To store all medicinal products dispensed or supplied to a resident securely at the center including any medications requiring additional controls under the Misuse of Drugs Regulations.

9. **Action Required:**
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

**Please state the actions you have taken or are planning to take:**
In accordance with legislative requirements and the centre’s policy on safe storage of medication, the PIC will ensure that all medicines are stored securely and appropriately. This includes any medications requiring additional controls under the Misuse of Drugs Regulations.

Nursing staff will have access to Medication Management training which includes information regarding safe storage of medications. Medications not in current use will be returned to the Pharmacy in accordance with the centre’s policy on disposal of unused medicinal products.

**Proposed Timescale:** 28/02/2018
### Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

10. **Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

**Please state the actions you have taken or are planning to take:**
A review of care plans will be conducted by the PIC and CNM. Nurses will be educated and supervised to adhere to professional guidelines and the need for ongoing review of residents’ healthcare needs and the use of the available appropriate assessment and care planning tools.

**Proposed Timescale:** 31/03/2018

### Outcome 16: Residents' Rights, Dignity and Consultation

**Theme:**
Person-centred care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
To provide opportunities for residents to participate in activities in accordance with their interests and capacities including ensuring that the role of the activity coordinators can dedicate their time to providing activities for all residents.

11. **Action Required:**
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

**Please state the actions you have taken or are planning to take:**
A review of the provision of activities is underway. Training is being planned for the activity co-ordinators to ensure that they are suitably equipped to provide a variety of meaningful activities for all residents, based on their expressed choices and preferences.
**Proposed Timescale:** 31/03/2018

<table>
<thead>
<tr>
<th><strong>Outcome 18: Suitable Staffing</strong></th>
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<tr>
<td><strong>Theme:</strong> Workforce</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

12. **Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Staffing has been reviewed and will continuously be monitored to ensure that the number and skill mix of staff is appropriate to the number, dependency levels and assessed care needs of the residents.

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**Proposed Timescale:** 31/01/2018

| **Theme:** Workforce |

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that staff have access to appropriate training including manual/patient handling training.

13. **Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
A training plan is in place and training, including manual/patient handling has been scheduled to ensure that all staff have completed appropriate training.

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**Proposed Timescale:** 31/03/2018

| **Theme:** Workforce |

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
To ensure that staff are appropriately supervised.

14. **Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
The appointment of a new CNM and Senior Staff Nurse along with the input of the PIC will ensure that staff are appropriately supervised.

**Proposed Timescale:** 31/01/2018